

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

9064

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09018

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 11yr. 2mo. 18das. 13 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS 14 West End Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Emily Last Adams		4. DATE OF DEATH Month August Day 10 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-7-95
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. Adams		14. MOTHER'S MAIDEN NAME Tryphina Evans	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -	
INFORMANT Address RECORDS - Eastern Shore State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 5, 1959 to August 10, 1959 , that I last saw the deceased alive on August 10, 1959 , and that death occurred at 11 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE George H. Langley M.D.		M.D. E.S.S. Hospital, Cambridge, Md. 8-11-59	
PHYSICIAN'S NAME (Type) George Longley, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 8/13/59		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY CAMBRIDGE CEMETERY		22d. LOCATION (City, town, or county) (State) CAMBRIDGE MD	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPTE FUNERAL SERVICE		ADDRESS CAMBRIDGE, MD REG'D BY REGISTRAR DATE AUG 13 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kiana	

RESULTS

1. 6. 2001

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9048

CERTIFICATE OF DEATH

10175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		/d. STREET ADDRESS R.F.D. #2	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ROY Middle LEE Last BEASLEY		4. DATE OF DEATH Month August Day 22 Year 19 59	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-26-59
9. AGE (In years last birthday) yrs. 1 Months 27 Days 27 Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
10b. KIND OF BUSINESS OR INDUSTRY -- --		11. BIRTHPLACE (State or foreign country) Dorchester County	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Walter Jones		14. MOTHER'S MAIDEN NAME Sally Mae Beasley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -- --	
17. INFORMANT Records of Cambridge-Maryland Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Broncho-pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Inanition DUE TO (c) 1 month		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -- --		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -- --	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. --		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- --		20f. (City or town) (County) (State) -- --	
21. I certify that I attended the deceased from 6-26-59 , 19 59 , to 8-22-59 , 19 59 , that I last saw the deceased alive on 8-22-59 , 19 59 , and that death occurred at 5:10AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Eldridge H. Wolff M.D. 15 Locust Street, Cambridge, Md. 8-22-59			
ACTUAL SIGNATURE Eldridge H. Wolff		PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/22/1959	
22c. NAME OF CEMETERY OR CREMATORY Salem Cemetery		22d. LOCATION (City, town, or county) (State) Dorchester Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thomas		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR SEP 29 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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CERTIFICATE OF DEATH

5049

1. NAME OF DECEASED JAMES EARL RAY		2. PLACE OF BIRTH MOBILE, ALABAMA	
3. SEX Male		4. AGE 35	
5. OCCUPATION None		6. MARITAL STATUS Single	
7. DATE OF DEATH April 4, 1968		8. PLACE OF DEATH MEMPHIS, TENNESSEE	
9. CAUSE OF DEATH Shot - Gun		10. MANNER OF DEATH Suicide	
11. SIGNATURE OF PHYSICIAN J. Edgar Hoover		12. SIGNATURE OF CORONER J. Edgar Hoover	
13. SIGNATURE OF WITNESS J. Edgar Hoover		14. SIGNATURE OF DECEASED J. Edgar Hoover	
15. SIGNATURE OF DECEASED J. Edgar Hoover		16. SIGNATURE OF DECEASED J. Edgar Hoover	
17. SIGNATURE OF DECEASED J. Edgar Hoover		18. SIGNATURE OF DECEASED J. Edgar Hoover	
19. SIGNATURE OF DECEASED J. Edgar Hoover		20. SIGNATURE OF DECEASED J. Edgar Hoover	
21. SIGNATURE OF DECEASED J. Edgar Hoover		22. SIGNATURE OF DECEASED J. Edgar Hoover	
23. SIGNATURE OF DECEASED J. Edgar Hoover		24. SIGNATURE OF DECEASED J. Edgar Hoover	
25. SIGNATURE OF DECEASED J. Edgar Hoover		26. SIGNATURE OF DECEASED J. Edgar Hoover	
27. SIGNATURE OF DECEASED J. Edgar Hoover		28. SIGNATURE OF DECEASED J. Edgar Hoover	
29. SIGNATURE OF DECEASED J. Edgar Hoover		30. SIGNATURE OF DECEASED J. Edgar Hoover	
31. SIGNATURE OF DECEASED J. Edgar Hoover		32. SIGNATURE OF DECEASED J. Edgar Hoover	
33. SIGNATURE OF DECEASED J. Edgar Hoover		34. SIGNATURE OF DECEASED J. Edgar Hoover	
35. SIGNATURE OF DECEASED J. Edgar Hoover		36. SIGNATURE OF DECEASED J. Edgar Hoover	
37. SIGNATURE OF DECEASED J. Edgar Hoover		38. SIGNATURE OF DECEASED J. Edgar Hoover	
39. SIGNATURE OF DECEASED J. Edgar Hoover		40. SIGNATURE OF DECEASED J. Edgar Hoover	
41. SIGNATURE OF DECEASED J. Edgar Hoover		42. SIGNATURE OF DECEASED J. Edgar Hoover	
43. SIGNATURE OF DECEASED J. Edgar Hoover		44. SIGNATURE OF DECEASED J. Edgar Hoover	
45. SIGNATURE OF DECEASED J. Edgar Hoover		46. SIGNATURE OF DECEASED J. Edgar Hoover	
47. SIGNATURE OF DECEASED J. Edgar Hoover		48. SIGNATURE OF DECEASED J. Edgar Hoover	
49. SIGNATURE OF DECEASED J. Edgar Hoover		50. SIGNATURE OF DECEASED J. Edgar Hoover	
51. SIGNATURE OF DECEASED J. Edgar Hoover		52. SIGNATURE OF DECEASED J. Edgar Hoover	
53. SIGNATURE OF DECEASED J. Edgar Hoover		54. SIGNATURE OF DECEASED J. Edgar Hoover	
55. SIGNATURE OF DECEASED J. Edgar Hoover		56. SIGNATURE OF DECEASED J. Edgar Hoover	
57. SIGNATURE OF DECEASED J. Edgar Hoover		58. SIGNATURE OF DECEASED J. Edgar Hoover	
59. SIGNATURE OF DECEASED J. Edgar Hoover		60. SIGNATURE OF DECEASED J. Edgar Hoover	
61. SIGNATURE OF DECEASED J. Edgar Hoover		62. SIGNATURE OF DECEASED J. Edgar Hoover	
63. SIGNATURE OF DECEASED J. Edgar Hoover		64. SIGNATURE OF DECEASED J. Edgar Hoover	
65. SIGNATURE OF DECEASED J. Edgar Hoover		66. SIGNATURE OF DECEASED J. Edgar Hoover	
67. SIGNATURE OF DECEASED J. Edgar Hoover		68. SIGNATURE OF DECEASED J. Edgar Hoover	
69. SIGNATURE OF DECEASED J. Edgar Hoover		70. SIGNATURE OF DECEASED J. Edgar Hoover	
71. SIGNATURE OF DECEASED J. Edgar Hoover		72. SIGNATURE OF DECEASED J. Edgar Hoover	
73. SIGNATURE OF DECEASED J. Edgar Hoover		74. SIGNATURE OF DECEASED J. Edgar Hoover	
75. SIGNATURE OF DECEASED J. Edgar Hoover		76. SIGNATURE OF DECEASED J. Edgar Hoover	
77. SIGNATURE OF DECEASED J. Edgar Hoover		78. SIGNATURE OF DECEASED J. Edgar Hoover	
79. SIGNATURE OF DECEASED J. Edgar Hoover		80. SIGNATURE OF DECEASED J. Edgar Hoover	
81. SIGNATURE OF DECEASED J. Edgar Hoover		82. SIGNATURE OF DECEASED J. Edgar Hoover	
83. SIGNATURE OF DECEASED J. Edgar Hoover		84. SIGNATURE OF DECEASED J. Edgar Hoover	
85. SIGNATURE OF DECEASED J. Edgar Hoover		86. SIGNATURE OF DECEASED J. Edgar Hoover	
87. SIGNATURE OF DECEASED J. Edgar Hoover		88. SIGNATURE OF DECEASED J. Edgar Hoover	
89. SIGNATURE OF DECEASED J. Edgar Hoover		90. SIGNATURE OF DECEASED J. Edgar Hoover	
91. SIGNATURE OF DECEASED J. Edgar Hoover		92. SIGNATURE OF DECEASED J. Edgar Hoover	
93. SIGNATURE OF DECEASED J. Edgar Hoover		94. SIGNATURE OF DECEASED J. Edgar Hoover	
95. SIGNATURE OF DECEASED J. Edgar Hoover		96. SIGNATURE OF DECEASED J. Edgar Hoover	
97. SIGNATURE OF DECEASED J. Edgar Hoover		98. SIGNATURE OF DECEASED J. Edgar Hoover	
99. SIGNATURE OF DECEASED J. Edgar Hoover		100. SIGNATURE OF DECEASED J. Edgar Hoover	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
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VS A15 (4)
1SM 9/58

9049

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09020

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 9 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lena Middle Elizabeth Last Bell		4. DATE OF DEATH Month August Day 30 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1885
9. AGE (In years last birthday) 74 yrs.		10. UNDER 1 YEAR Months 7 Days 10 Hours 10 Min.	11. UNDER 24 HRS. Months 7 Days 10 Hours 10 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Murphy		14. MOTHER'S MAIDEN NAME Elizabeth Wainwright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-20-4734	
17. INFORMANT Mrs. Glen Wilson, Rhodesdale, Md., R.F.D.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) NEPHROSCLEROSIS 446X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 1 YEAR	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/15, 1958 to 8/30, 1959 that I last saw the deceased alive on 8/30, 1959 , and that death occurred at 7:10 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 105 Church St. Cambridge Md. DATE SIGNED 9/1/59			
ACTUAL SIGNATURE Walter E. Gunby Jr. M.D.		DATE SIGNED 9/1/59	
PHYSICIAN'S NAME (Type) WALTER E. GUNBY JR		ADDRESS Cambridge	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 2, 1959	
22c. NAME OF CEMETERY OR CREMATORY Brookview Cemetery		22d. LOCATION (City, town, or county) (State) Brookview, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE SEP 4 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Krand			

2202

24-541

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death. The law requires that the death certificate be executed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9050

CERTIFICATE OF DEATH

09021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write CAMBRIDGE and give nearest town)		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) CAMBRIDGE MARYLAND HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle - T Last B ELL		4. DATE OF DEATH Month AUG Day 25 Year 19 59	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 6 1875
9. AGE (In years lost 84 day) 84 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMER	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LEVIN BELL		14. MOTHER'S MAIDEN NAME RACHAEL LINTHICUM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT J SPICER BELL		Address CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VIRUS PNEUMONIA 331X DUE TO (b) CEREBRAL HEMORRHAGE DUE TO (c) ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 11 DAYS 7 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/19 , 19 59 , to 8/25 , 19 59 , that I last saw the deceased alive on 8/25 , 19 59 , and that death occurred at 9:20 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Alfred R. Maryanov M.D.		ADDRESS (Street, city or town, state) 136 RACE ST	
PHYSICIAN'S NAME (Type) ALFRED R. MARYANOV		DATE SIGNED 8/26/59	
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF AUG 28, 1959	
22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEMORIAL PARK		22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LE COMPTE FUNERAL SERVICE		24a. REC'D BY REGISTRAR DATE SEP 1 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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1980

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

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FOR STATE
HEALTH DEPT.

9065

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09022

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>1yr. 1mo. 26das.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wittman</u> <u>20x-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>			d. STREET ADDRESS <u>--</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Peck</u> Last <u>Brandow</u>			4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28, 1887</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Charles Brandow</u>		
14. MOTHER'S MAIDEN NAME <u>Manie Marshall</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>		
16. SOCIAL SECURITY NO. <u>212-16-1270</u>		17. INFORMANT <u>Eastern Shore State Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. (c)					INTERVAL BETWEEN ONSET AND DEATH <u>2 days.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture 7, 8, 9 th. ribs left.</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Unknown</u>			
20c. TIME OF INJURY Month, Day, Year <u>8-6-1959</u> Hour <u> </u> a. m. <u> </u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u>	20f. (City or town) <u>Cambridge</u>	(County) <u>Dor.</u>	(State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/20/59</u>	
EXAMINER'S NAME (Type) <u>John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Olivet Cemetery</u>	22d. LOCATION (City, town, or county) <u>St. Michaels Md.</u>	(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. Hambleton Harrison</u>		ADDRESS <u>St. Michaels Md.</u>		24a. REC'D BY REGISTRAR <u>AUG 24 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kenna</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

NAME OF DECEASED		SEX		AGE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		M		45		10-10-1918		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL	
1000 N. E. ST.		LABORER		HEART DISEASE		NATURAL		CATHOLIC CHURCH	
CITY		COUNTY		STATE		CITY		COUNTY	
BALTIMORE		BALTIMORE		MD.		BALTIMORE		BALTIMORE	
DATE OF EXAMINATION		BY		SIGNATURE		TITLE		OFFICE	
10-10-1918		J. H. HARRIS		J. H. HARRIS		M.D.		BALTIMORE	
TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE		TITLE		OFFICE	
10-10-1918		1000 N. E. ST.		J. H. HARRIS		M.D.		BALTIMORE	
TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE		TITLE		OFFICE	
10-10-1918		1000 N. E. ST.		J. H. HARRIS		M.D.		BALTIMORE	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled with the information by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be filled with the information by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 6247 9-1-59 et

9051

CERTIFICATE OF DEATH

09023

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linkwood			
c. LENGTH OF STAY IN lb 1 Days				d. STREET ADDRESS None			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge, Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Phryn Middle Fetter Last Burke				4. DATE OF DEATH Month 8 Day 22 Year 1959			
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/1883		9. AGE (In years last birthday) 75 1/2 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Davis Fetter			14. MOTHER'S MAIDEN NAME Sue Ross				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.			16. SOCIAL SECURITY NO. NO.		INFORMANT Address Edna Burke, Linkwood, Maryland.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 2 month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6/15 , 19 59 , to 8/22 , 19 59 , that I last saw the deceased alive on 8/22 , 19 59 , and that death occurred at 5:15 P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Lawrence Maryanov M.D.				ADDRESS (Street, city or town, state) 136 Race St. Cambridge, Md			
PHYSICIAN'S NAME (Type) Lawrence Maryanov				DATE SIGNED 8/25/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/24/59		22c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park.		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md..				24a. REC'D BY REGISTRAR AUG 26 '59		24b. REGISTRAR'S SIGNATURE Carlton S. Hume	

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067

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CERTIFICATE OF DEATH

2081

Northwestern Co.

San Antonio

Northwestern Co.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

9066

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09024

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsburg</u>		c. LENGTH OF STAY IN 1b <u>14 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		d. STREET ADDRESS <u>Williamsburg</u>	
3. NAME OF DECEASED (Type or print) <u>Mattie</u> First <u>S.</u> Middle <u>Camper</u> Last		4. DATE OF DEATH <u>August 21</u> Month <u>21</u> Day <u>1959</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Heavitt, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Benjamin Jones</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Harimore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-094688</u>	
17. INFORMANT <u>Mrs. Harrington Smith, Williamsburg, Md.</u>		Address <u>Williamsburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Cardiac Congestive Failure</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Hypertensive Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u> <u>10-12 yrs</u> <u>10-14 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/10</u> , 19 <u>56</u> , to <u>8/21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8/20</u> , 19 <u>59</u> , and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry B. Plummer</u> M.D.		ADDRESS (Street, city or town, state) <u>P.O. Box 184 Preston Md.</u> DATE SIGNED <u>8/21/59</u>	
PHYSICIAN'S NAME (Type) <u>Henry B. Plummer MD</u>		<u>P.O. Box 184 Preston Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 23, 1959</u>		22b. DATE THEREOF <u>Aug 23, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Heavitt Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Heavitt, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Hamblton Harrison</u>		ADDRESS <u>St. Michael's Md.</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Kline</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
DATE <u>AUG 25 '59</u>			

CERTIFICATE OF DEATH

0066

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1900

DATE OF DEATH

PLACE TO BE FURNISHED

DECEASED

NAME OF DECEASED
JAMES H. HARRIS
AGE 174
SEX M
RACE W
BORN 1825
DIED 1900

PLACE OF DEATH
HARRIS

CAUSE OF DEATH
DIED

DATE OF DEATH
1900

PLACE OF DEATH
HARRIS

CAUSE OF DEATH
DIED

DATE OF DEATH
1900

PLACE OF DEATH
HARRIS

CAUSE OF DEATH
DIED

DATE OF DEATH
1900

PLACE OF DEATH
HARRIS

CAUSE OF DEATH
DIED

DATE OF DEATH
1900

PLACE OF DEATH
HARRIS

1

1900

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9052

CERTIFICATE OF DEATH

09025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 439 High Street		d. STREET ADDRESS 1 439 High Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Paul Last Cephas		4. DATE OF DEATH Month August Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1886
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Columbus Cephas		14. MOTHER'S MAIDEN NAME Emma Waters	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Evelyn Cephas, Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1958 , to August 1, 1959 , that I last saw the deceased alive on August 1, 1959 , and that death occurred at 2p. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 227 Pine St-Cambridge, Md. DATE SIGNED 8-4-59 ACTUAL SIGNATURE J. Edwin Fassett, M.D. M.D. 227 Pine St-Cambridge, Md. 8-4-59 PHYSICIAN'S NAME (Type) J. Edwin Fassett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/4/1959	
22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kraus		24a. REC'D BY REGISTRAR DATE AUG 12 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9067

CERTIFICATE OF DEATH

Reg. Dist. No.

09026

1. PLACE OF DEATH a. COUNTY Wicomico Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 4 mo. 8 das.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS Rt. 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lou Nettie Middle Alice Last Chatham				4. DATE OF DEATH Month August Day 20 Year 1959			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1882 ? Dec, 6	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY OWN - Home.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Lewis Chatham				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE.			
INFORMANT RECORDS - Eastern Shore State Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 443X							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from April 12 , 19 59 , to August 20 , 19 59 , that I lost sow the deceased olive on August 20 , 19 59 , and that death occurred at 7:05 PM , from the causes ond on the date stated above. ADDRESS (Street, city or town, state) E. S.S. Hospital, Cambridge, Md. DATE SIGNED 8-21-59							
ACTUAL SIGNATURE E. DeFilippis				PHYSICIAN'S NAME (Type) E. DeFilippis			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 8/23/1959			
22c. NAME OF CEMETERY OR CREMATORY Silom Cemetery				22d. LOCATION (City, town, or county) (State) Silom, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Hill + Johnson Co. Salisbury, Md.				24a. REC'D BY REGISTRAR Norman F Barber.			
24b. REGISTRAR'S SIGNATURE Arthur L. Kline				DATE AUG 24 '59			

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M

STATE **Virginia** COUNTY **Accomack**

83x-3

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

P.O. Box 44

Yes

19 59

IF UNDER 24 HRS

Hours	Min
-------	-----

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

Mary Watson

Address _____

227-20-2642 John Dickerson, Horntown, Va.

INTERVAL BETWEEN...

Coronary occlusion

Instant

DUE TO

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

(State)

21. I **certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

DATE SIGNED _____

DEPUTY MEDICAL EXAMINER

(Slot)

Hornstown Va.

24b. REGISTRAR'S SIGNATURE

J. J. Frampton and Son, Federalsburg, Maryland

240. REC'D BY REGISTRAR
AUG 24 '59

Arthur S. Kraus

VS. AISME
SM 2/57

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 78
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED James D. Peterson		SEX Male	
DATE OF BIRTH Jan. 22, 1900		AGE 28	
PLACE OF BIRTH Baltimore, Md.		RESIDENCE Baltimore, Md.	
OCCUPATION None		CAUSE OF DEATH None	
MANNER OF DEATH None		SIGNATURE OF EXAMINER None	
DATE OF EXAMINATION None		PLACE OF EXAMINATION None	
FAMILY HISTORY None		SOCIAL HISTORY None	
MEDICAL HISTORY None		PATHOLOGICAL HISTORY None	
LABORATORY TESTS None		RADIOLOGICAL TESTS None	
TREATMENT None		POST-MORTEM None	
FOLLOW-UP None		REMARKS None	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9053

CERTIFICATE OF DEATH

Reg. Dist. No.

09030

1. PLACE OF DEATH a. DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY DORCHESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE	c. LENGTH OF STAY IN 1b 1 DAY	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CAMBRIDGE MARYLAND HOSP.		d. STREET ADDRESS 13 903 ROSLYN AVE	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First STEPHEN Middle F Last HAYES		4. DATE OF DEATH Month AUG Day 26 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 20 1959
10a. USUAL OCCUPATION (Give kind of work done during most of working life and for how long) Working line & not specified		10b. KIND OF BUSINESS OR INDUSTRY *****	9. AGE (In years, lost 3 months) 3 MONTHS
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DENNIS HAYES		14. MOTHER'S MAIDEN NAME ANNA L CROSBY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT DENNIS HAYES		Address CAMBRIDGE MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHIAL VIRUS INFECTION 501X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) WITH HYPERPYREXIA AND CONVULSIONS DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 20 , 19 59 , to Aug. 26 , 19 59 , that I last saw the deceased alive on Aug. 26 , 19 59 , and that death occurred at 5:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>Albert E. Bunker</i> M.D. 200 Maryland Avenue 8-28-59 PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D. CAMBRIDGE, MARYLAND			
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL	22b. DATE THEREOF AUG 28 1959	22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEMORIAL PARK	22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE LEE COMPTON FUNERAL SERVICE		24a. REC'D BY REGISTRAR DATE SEP 1 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

2067263XY4

10030

STANDARD INVESTIGATION OF HEALTH CARE

CERTIFICATE OF DEATH

9028

DECEASED		DATE OF DEATH		PLACE OF DEATH	
NAME		AGE		SEX	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
OCCUPATION		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
DATE OF DEATH		PLACE OF DEATH		CITY	
OCCUPATION		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	

DECEASED		DATE OF DEATH		PLACE OF DEATH	
NAME		AGE		SEX	
DATE OF BIRTH		PLACE OF BIRTH		CITY	
OCCUPATION		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	
DATE OF DEATH		PLACE OF DEATH		CITY	
OCCUPATION		EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSM(E)
SM 9/55

1
9054 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09031

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>---</u>				d. STREET ADDRESS <u>111 1/2 South Main Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Henry</u> Last <u>Hoff, Jr.</u>				4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 17, 1915</u>	
9. AGE (In years last birthday) <u>44</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>15</u>		IF UNDER 24 HRS. Hours <u>---</u> Min. <u>---</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner-Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Western Auto Store</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore City, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Henry Hoff, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Helen C. McKaig</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-01-0087</u>		17. INFORMANT Address <u>Mrs Marion G. Hoff, S. Main St., Federalsburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular renal disease</u> (c) <u>---</u> DUE TO cause last, stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u> <u>unknown</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>---</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>---</u> p. m. <u>---</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>		20f. (City or town) (County) (State) <u>---</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-4-59</u>	
EXAMINER'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>August 5, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton and Son, Federalsburg, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knecht</u>	

9055

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Linda Middle Marlene Last Hughes		4. DATE OF DEATH Month August Day 24 Year 19 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 22, 1959
9. AGE (In years last birthday) yrs. 2		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R. Hughes		14. MOTHER'S MAIDEN NAME Regina Cannon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
INFORMANT George R. Hughes, Hurlock, Maryland		Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity - Prematurity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 22 , 19 59 , to Aug. 24 , 19 59 , that I last saw the deceased alive on Aug. 23 , 19 59 , and that death occurred at 3:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert E. Bunker		DATE SIGNED 8-26-59	
PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.		CAMBRIDGE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 26, 1959	22c. NAME OF CEMETERY OR CREMATORY Petersburg Cemetery	
22d. LOCATION (City, town, or county) (State) Near Hurlock, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland		24a. REC'D BY REGISTRAR DATE SEP 3 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Kinas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2067291XV0

CERTIFICATE OF DEATH

18

100000



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9056

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

10181

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna Cambridge				c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Vienna	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital				d. STREET ADDRESS 1 none		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Augustus Middle Lee Last Jackson				4. DATE OF DEATH Month August Day 31 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-15-91	
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter				10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Oliver Jackson				14. MOTHER'S MAIDEN NAME Marie Austin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Mrs. Mary Frances Jackson, Vienna, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO renal disease. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic hypertensive cardio vascular DUE TO (c) Arteriosclerosis generalized				INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hours 1 year + 1 years +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -- -- --				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -- -- --			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. -- -- -- 19				20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -- -- --	
20f. (City or town) -- -- --				20g. (County) -- -- --		20h. (State) -- -- --	
21. I certify that I attended the deceased from 4-24-59 , 19 59 , to 8-3-59 , 19 59 , that I last saw the deceased alive on 8-3-59 , 19 59 , and that death occurred at 4:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 15 Locust Street, Cambridge, Md. DATE SIGNED 9-4-59 ACTUAL SIGNATURE Eldridge H. Wolff M.D. 15 Locust Street, Cambridge, Md. PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-3-59		22c. NAME OF CEMETERY OR CREMATORY Mardella		22d. LOCATION (City, town, or county) (State) Mardella Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Paul McLaughlin				ADDRESS East New Market, Maryland		24a. REC'D BY REGISTRAR SEP 10 59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kline			

10121

WYOMING STATE DEPARTMENT OF HEALTH - BATHING, 18

0033

CERTIFICATE OF DEATH

Page One of One

1. Name of deceased JAMES H. HARRIS		2. Sex Male		3. Age 65		4. Date of birth 1874		5. Place of birth New York		6. Usual residence New York		7. Cause of death Heart disease		8. Date of death 1933		9. Place of death New York		10. Signature of physician J. H. Harris		11. Signature of registrar J. H. Harris		12. Signature of informant J. H. Harris	
13. Name of informant J. H. Harris		14. Relationship to deceased Son		15. Address of informant New York		16. Date of completion of report 1933		17. Name of registrar J. H. Harris		18. Signature of registrar J. H. Harris		19. Name of physician J. H. Harris		20. Signature of physician J. H. Harris		21. Name of informant J. H. Harris		22. Signature of informant J. H. Harris		23. Name of informant J. H. Harris		24. Signature of informant J. H. Harris	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09033

Reg. Dist. No.

9057

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 3 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Vienna - Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge-Maryland Hospital				d. STREET ADDRESS R.F.D. #1, Box 12		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clyde Middle Jackson Last Sr.				4. DATE OF DEATH Month August Day 27 Year 1959			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1892		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months 67 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Day laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning Factory		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alex Jackson				14. MOTHER'S MAIDEN NAME Henrietta Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-12-3504		17. INFORMANT Myra Jackson, Vienna, Maryland, R.F.D. #1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL-VASCULAR ACCIDENT DUE TO Conditions, if any, which gave rise to immediate cause (b) HYPERTENSIVE HT. DISEASE (c), stating the underlying cause lost. DUE TO UNDET							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 HRS							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 0 p. m. 0		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Alfred R. Maryanov				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) ALFRED R. MARYANOV, MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF August 30, 1959		22c. NAME OF CEMETERY OR CREMATORY Vienna Cemetery		22d. LOCATION (City, town, or county) (State) Vienna, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J.J. Frampton and Son, Federalsburg, Maryland				24a. REC'D BY REGISTRAR SEP 3 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Hines	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

FOR STATE
HEALTH DEPT.

9058

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09034

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>None</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	c. LENGTH OF STAY IN 1b <u>10 Min.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	<u>3V01-4</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>		d. STREET ADDRESS <u>3604 Greenmount Ave.</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Anne Murray Lynch</u>	4. DATE OF DEATH <u>August 22nd</u> 1959	5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Jan/11/20</u> 9. AGE (In years last birthday) <u>39</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Buss. office</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Daniel A. Lynch</u> 14. MOTHER'S MAIDEN NAME <u>Helen A. Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u> 17. INFORMANT <u>Miss Patricia Lynch, Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of Brain</u> DUE TO (b) <u>Fracture of Skull</u> DUE TO (c) <u>Train striking auto</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 hour</u> <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of Left radius & 4 left ribs</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto struck by a train</u>	
20c. TIME OF INJURY <u>2:45 PM</u> a.m. <u>Aug. 22</u> 1959	20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) <u>Linkwood, Dorchester, Maryland</u> (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>8/22/59</u>	
EXAMINER'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/26/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>	22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. Mears & Son</u>		24a. REC'D BY REGISTRAR <u>AUG 26 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arline & Hines</u>	

9059

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09035

Reg. Dist. No.

FOR STATE
HEALTH-DEPT.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>none</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN lb <u>10 Minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>			d. STREET ADDRESS <u>3604 Greenmount ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Daniel James Lynch</u>			4. DATE OF DEATH Month <u>Aug.</u> Day <u>22nd</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8 June '21</u>		9. AGE (In years last birthday) <u>38</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Comm. Air Line</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Daniel A. Lynch</u>			14. MOTHER'S MAIDEN NAME <u>Helen A. Brown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>1941-1946</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Miss Patricia Lynch, Balto. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of Brain</u> <u>810 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracture of Skull</u> DUE TO (c) <u>Train striking auto</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 hour</u> <u>1 hour</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Massive fracture of mandible, fracture of left clavicle</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto struck by train</u>			
20c. TIME OF INJURY Month, Day, Year <u>2:45 PM</u> <u>Aug. 22</u> <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
				20f. (City or town) (County) (State) <u>Linkwood, Dorchester, Maryland</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>		EXAMINER'S NAME (Type) <u>Eldridge H. Wolff, M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u>	
				22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. W. Mears & Son 805 N. Calvert St.</u>			24a. REC'D BY REGISTRAR DATE <u>AUG 26 '59</u>		
			24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		

FOR STATE
HOSPITAL

0055

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



RECEIVED
BALTIMORE
MAY 10 1918
DEPARTMENT OF HEALTH

1. Name of deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Usual residence: _____

7. Cause of death: _____

8. Date of death: _____

9. Signature of medical examiner: _____

10. Signature of coroner: _____

11. Signature of physician: _____

12. Signature of undertaker: _____

13. Signature of funeral home: _____

14. Signature of family: _____

15. Signature of neighbor: _____

16. Signature of clergyman: _____

17. Signature of other: _____

18. Signature of other: _____

19. Signature of other: _____

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99. Signature of other: _____

100. Signature of other: _____

9069

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY DORCHESTER MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE		c. LENGTH OF STAY IN 1b 3YRS 6 MOS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION EASTERN SHORE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROXIE FRANCES NELSON		4. DATE OF DEATH Month Day Year AUGUST 9 1959	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 3 1974
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE STERLING		14. MOTHER'S MAIDEN NAME MARY ELIZABETH MADRIX	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. HOSPITAL RECORDS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DIABETES MELLITIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 HRS. 8 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC BRAIN SYNDROME SENILE BRAIN DISEASE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from APR. 25 , 19 57 , to AUG. 9 , 19 59 , that I last saw the deceased alive on AUG. 8 , 19 59 , and that death occurred at 12:50 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Harry J. Crawford		M.D. EASTERN SHORE STATE HOSPITAL AUG 9 1959	
PHYSICIAN'S NAME (Type) HARRY J. CRAWFORD MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 8-11-59	22c. NAME OF CEMETERY OR CREMATORY SPRING BRIDGE	22d. LOCATION (City, town, or county) (State) Hopewell Md.
23. FUNERAL DIRECTOR'S SIGNATURE L. S. Webster		24. REC'D BY REGISTRAR DATE AUG 12 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. France	

2003

CERTIFICATE OF DEATH

THE STATE OF NEW YORK

10030

DECEASED

PLATT

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CANDIDATE

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CRISTAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9060

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G246 8-24-59 et

CERTIFICATE OF DEATH

09037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 11 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge-Maryland Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Herman Alexander Oehlrich		4. DATE OF DEATH Month Day Year August 18, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889 August 20, 1959
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 MRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cook & Baker		10b. KIND OF BUSINESS OR INDUSTRY Virginia	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Herman A. Oehlrich, Sr.		14. MOTHER'S MAIDEN NAME Rita Schleif	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War 1		16. SOCIAL SECURITY NO. Mrs. Mattie A. Oehlrich, 221 Maynard St., Cambridge, Md.	
17. INFORMANT Mrs. Mattie A. Oehlrich, 221 Maynard St., Cambridge, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pneumonia - Left Lower Lobe		INTERVAL BETWEEN ONSET AND DEATH 3 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/27 to 8/19 , 19 59 , that I last saw the deceased alive on 8/19/59 , 19 59 , and that death occurred at 10:45 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Albert E. Bunker		DATE SIGNED 8/19/59	
PHYSICIAN'S NAME (Type) ALBERT E. BUNKER, M. D.		CAMBRIDGE, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 20, 1959	
22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		22d. LOCATION (City, town, or county) (State) Oxford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Throckmold		ADDRESS Cambridge, Md.	
24a. REC'D BY REGISTRAR DATE AUG 21 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

9070

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - CAMBRIDGE</u>				c. LENGTH OF STAY IN 1b <u>3 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSP.</u>				d. STREET ADDRESS <u>317 N. AURORA ST.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>F.</u> Last <u>OZMAN</u>				4. DATE OF DEATH Month <u>AUG.</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 17, 1881</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BASCOM OZMAN</u>				14. MOTHER'S MAIDEN NAME <u>NANCY ? Sherwood</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		INFORMANT Address <u>EASTERN SHORE STATE HOSP. RECORDS.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED ARTERIOSCLEROSIS.</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 YRS.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>AUG. 24</u> , 19 <u>59</u> , to <u>AUG. 24</u> , 19 <u>59</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>7:15</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>George H. Longley</u> M.D. <u>RED 2, CAMBRIDGE, MD. AUG. 24, 1959</u> PHYSICIAN'S NAME (Type) <u>GEORGE H. LONGLEY</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Aug 27, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) _____ (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Newman & Son</u>		ADDRESS <u>Easton</u>		24a. REC'D BY REGISTRAR <u>Aug 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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CERTIFICATE OF DEATH

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09039

Reg. Dist. No.

1. PLACE OF BIRTH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Doe</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Shulock</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Shulock</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asheer Nursing Home</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Caroline Pauline Palmer</u>		4. DATE OF DEATH <u>8/20</u> 1959	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/20/1884</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Grupe</u>		14. MOTHER'S MAIDEN NAME <u>Elise Rumpf</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>Living C. Palmer, Shulock, Md.</u>	
17. INFORMANT <u>Living C. Palmer, Shulock, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>20 yrs.</u> <u>20 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Left Hip.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Pt Fell at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-20</u> , 1958, to <u>8-18</u> , 1959, that I last saw the deceased alive on <u>8-18</u> , 1959, and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>Im Trappell</u> M.D. <u>126 Bloomingdale Ave</u> <u>8-24-59</u>			
PHYSICIAN'S NAME (Type) <u>H.R. Trappell</u> <u>Federalburg, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>2-3-59</u>		22b. DATE THEREOF <u>3/23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Will S. Hollorphy, East New Market</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>SEP 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Living S. Kears</u>			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2502

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

9072

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09040

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN lb 2yr. 3mo. 8days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS -- e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Joseph Middle M. Last Robinson		4. DATE OF DEATH Month August Day 24 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1877 (?)
9. AGE (In years last birthday) 82 ? yrs.		IF UNDER 1 YEAR Months 2 Days 24 Hours 19 Min.	IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not reported		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 218-05-4744	
17. INFORMANT RECORDS: Eastern Shore State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO (a) (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture neck left femur		INTERVAL BETWEEN ONSET AND DEATH 1 day	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Fell from walker.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 12:40 PM. 7/16/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Cambridge Dor. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE John Mace, Jr.		DATE SIGNED 8/24/59	
EXAMINER'S NAME (Type) John Mace, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/27/59	
22c. NAME OF CEMETERY OR CREMATORY Chester Cem.		22d. LOCATION (City, town, or county) (State) Chestertown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR Aug 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

9073

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09042

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Queen Anne			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge				c. LENGTH OF STAY IN 1b 29 Mo's			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital				d. STREET ADDRESS None			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Barbara First Tehol Middle Last				4. DATE OF DEATH Aug 31 1959 Month Day Year			
5. SEX F		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 30 1893	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME No Record				14. MOTHER'S MARDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. NONE			
INFORMANT Address Eastern Shore State Hospital records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cholecystitis 585X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH LINK
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 27 1957 to Aug 31 1959 , that I last saw the deceased alive on Aug 30 1959 , and that death occurred at 4:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) E.S.S.H., Cambridge, Md. DATE SIGNED Aug 31 '59							
ACTUAL SIGNATURE Thomas J. Dredge M.D.							
PHYSICIAN'S NAME (Type) Thomas J. Dredge							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-3-59		22c. NAME OF CEMETERY OR CREMATORY Templerville		22d. LOCATION (City, town, or county) (State) Templerville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Bouleis Greensboro Md.				24a. REC'D BY REGISTRAR DATE SEP 3 '59		24b. REGISTRAR'S SIGNATURE Ciribus S. Kinas	

1000

WESTLAND STATEMENT OF DEBIT AND CREDIT

STATE OF OHIO

9073

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files. File, pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

1
9074 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10190
item 9 filing 849 9-25-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havlock c. LENGTH OF STAY IN 1b Unknown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Unknown		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last UNKNOWN		4. DATE OF DEATH Month Day Year Found August 22 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Approx.
9. AGE (In years last birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. Found August 22 19 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 929.8 Macerated decomposing body found drowned. DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found drowned.	
20c. TIME OF INJURY Month, Day, Year Hour 1:00 p. m. 8/22/59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Creek		20f. (City or town) (County) (State) Havlock Dorchester Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .			
ACTUAL SIGNATURE Charles S. Petty		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Petty, M.D.		DATE SIGNED 8/23/59	
22a. BURIAL (CREMATION, REMOVAL) (Specify) 9.22.59		22b. DATE THEREOF 9.22.59	
22c. NAME OF CEMETERY OR CREMATORY Volunteer Med. School		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 25 '59	
		24b. REGISTRAR'S SIGNATURE Arthur H. Hayes	

0072 - MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1942	
NAME OF DECEASED [Name]		SEX [Male/Female]	
AGE [Age]		RACE [Race]	
PLACE OF BIRTH [Place]		OCCUPATION [Occupation]	
MARITAL STATUS [Single/Married/Widowed]		CAUSE OF DEATH [Cause]	
MEDICAL HISTORY [History]		MANNER OF DEATH [Manner]	
SIGNATURE OF EXAMINER [Signature]		DATE OF EXAMINATION [Date]	
OFFICIAL USE [Official Use]		[Official Use]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9061

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G247 9-1-59 et

CERTIFICATE OF DEATH

09043

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge, Md.</u>			c. LENGTH OF STAY IN 1b <u>59 Years</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>213 Maryland, Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>M.</u> Last <u>Vane</u>			4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>19 59</u>		
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1/18/1881</u>		9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>James Rose</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Tucker.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		INFORMANT Address <u>Le Compte Funeral Home, Records.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>CORONARY HEART DISEASE</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC CHOLECYSTITIS</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>DECEMBER</u> , 19 <u>51</u> , to <u>8-20-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-21-59</u> , 19 <u>59</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>200 Maryland Avenue</u> DATE SIGNED <u>8-21-59</u> ACTUAL SIGNATURE <u>Albert E. Bunker</u> PHYSICIAN'S NAME (Type) <u>ALBERT E. BUNKER, M. D.</u> <u>CAMBRIDGE, MARYLAND</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Cemetary</u>	
22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Le Compte Funeral Service, Cambridge, Maryland.</u>		ADDRESS <u>Le Compte Funeral Service, Cambridge, Maryland.</u>		24a. REC'D BY REGISTRAR <u>AUG 26 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur E. Frank</u>					

CERTIFICATE OF DEATH

1901

Decatur Co. Maryland

Decatur Co. Maryland

Decatur Co. Maryland

Decatur Co. Maryland

Decatur Co. Maryland

Decatur Co. Maryland

Decatur Co. Maryland

Decatur Co. Maryland

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Decatur Co. Maryland

Decatur Co. Maryland

Decatur Co. Maryland

Decatur Co. Maryland

Decatur Co. Maryland

Decatur Co. Maryland

1
VS A15 (4)
ISM 9/58

TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				09044	
9075				CERTIFICATE OF DEATH	
Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock - Rural		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
c. LENGTH OF STAY IN lb 26 years		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Near Choptank		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Marion Middle Ryno Last Wands		4. DATE OF DEATH Month August Day 19 Year 19 59			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 29, 1877	9. AGE (In years last birthday) yrs. 81	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Plainfield, New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Ryno		14. MOTHER'S MAIDEN NAME Emma Gibbs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Sidney G. Wands, Hurlock, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 155.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General CARCINOMATOSIS - DUE TO Premalignant CARCINOMA Gall Bladder (c) with General Metastasis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Patient acquired Esophageal Tumor to General CARCINOMA with 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) General Metastasis. 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				INTERVAL BETWEEN ONSET AND DEATH 1 hour July 12 '59	
21. I certify that I attended the deceased from July 12, 1959 , to Aug 19, 1959 that I last saw the deceased alive on Aug 18, 1959 and that death occurred at 6:10 A.M. from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE W. E. Lennon		M.D. Federalsburg Md.		DATE SIGNED Federalsburg Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 22, 1959		22c. NAME OF CEMETERY OR CREMATORY Washington Cemetery	
22d. LOCATION (City, town, or county) Hurlock, Maryland		(State) 			
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland		ADDRESS 		24a. REC'D BY REGISTRAR DATE AUG 24 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Rues					

CERTIFICATE OF DEATH

9075

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

Decedent's Name: *John Doe*
Age: *45*
Sex: *Male*
Race: *White*
Date of Birth: *Jan 1, 1900*
Place of Birth: *Johns Hopkins*

Residence: *123 Main St, Baltimore, Md*
Cause of Death: *Heart Disease*
Manner of Death: *Natural*
Date of Death: *Jan 15, 1945*
Place of Death: *Home*

Physician: *Dr. J. H. Smith*
Signature: *[Signature]*
Date: *Jan 16, 1945*

Registrar: *[Signature]*
Date: *Jan 16, 1945*

Funeral Home: *Johns Hopkins*
Burial Place: *Johns Hopkins*

Interment: *Johns Hopkins*
Date of Interment: *Jan 17, 1945*

County: *Johns Hopkins*
Date of Death: *Jan 15, 1945*

Signature: *[Signature]*
Date: *Jan 16, 1945*

Signature: *[Signature]*
Date: *Jan 16, 1945*

9076

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09045

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Dor.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>		c. LENGTH OF STAY IN 1b <u>50 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Roland Linwood Wheatley</u>			
4. DATE OF DEATH Month Day Year <u>8 / 30 / 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/18/1892</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucking/Tractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Wheatley</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Collins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT Address <u>Marion L. Wheatley, Cambridge, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Gastric Hemorrhage</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Peptic ulcer</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN MACE JR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>		22d. LOCATION (City, town, or county) (State) <u>East New Market, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William S. Halloway</u>		24a. REC'D BY REGISTRAR <u>William S. Halloway</u>	
ADDRESS <u>East New Market</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Halloway</u>	
DATE <u>SEP 8 '59</u>		24c. REGISTRAR'S SIGNATURE <u>William S. Halloway</u>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BARNHART 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1078

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. DATE OF DEATH <i>10/15/1918</i>	
5. PLACE OF DEATH <i>Home</i>		6. CAUSE OF DEATH <i>Heart Disease</i>	
7. MANNER OF DEATH <i>Natural</i>		8. SIGNATURE OF EXAMINER <i>Dr. J. A. Smith</i>	
9. SIGNATURE OF NEXT OF KIN <i>John Doe</i>		10. SIGNATURE OF WITNESS <i>John Doe</i>	
11. SIGNATURE OF CLERK <i>John Doe</i>		12. SIGNATURE OF JURY <i>John Doe</i>	
13. SIGNATURE OF JURY <i>John Doe</i>		14. SIGNATURE OF JURY <i>John Doe</i>	
15. SIGNATURE OF JURY <i>John Doe</i>		16. SIGNATURE OF JURY <i>John Doe</i>	
17. SIGNATURE OF JURY <i>John Doe</i>		18. SIGNATURE OF JURY <i>John Doe</i>	
19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>	
21. SIGNATURE OF JURY <i>John Doe</i>		22. SIGNATURE OF JURY <i>John Doe</i>	
23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
25. SIGNATURE OF JURY <i>John Doe</i>		26. SIGNATURE OF JURY <i>John Doe</i>	
27. SIGNATURE OF JURY <i>John Doe</i>		28. SIGNATURE OF JURY <i>John Doe</i>	
29. SIGNATURE OF JURY <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
31. SIGNATURE OF JURY <i>John Doe</i>		32. SIGNATURE OF JURY <i>John Doe</i>	
33. SIGNATURE OF JURY <i>John Doe</i>		34. SIGNATURE OF JURY <i>John Doe</i>	
35. SIGNATURE OF JURY <i>John Doe</i>		36. SIGNATURE OF JURY <i>John Doe</i>	
37. SIGNATURE OF JURY <i>John Doe</i>		38. SIGNATURE OF JURY <i>John Doe</i>	
39. SIGNATURE OF JURY <i>John Doe</i>		40. SIGNATURE OF JURY <i>John Doe</i>	
41. SIGNATURE OF JURY <i>John Doe</i>		42. SIGNATURE OF JURY <i>John Doe</i>	
43. SIGNATURE OF JURY <i>John Doe</i>		44. SIGNATURE OF JURY <i>John Doe</i>	
45. SIGNATURE OF JURY <i>John Doe</i>		46. SIGNATURE OF JURY <i>John Doe</i>	
47. SIGNATURE OF JURY <i>John Doe</i>		48. SIGNATURE OF JURY <i>John Doe</i>	
49. SIGNATURE OF JURY <i>John Doe</i>		50. SIGNATURE OF JURY <i>John Doe</i>	
51. SIGNATURE OF JURY <i>John Doe</i>		52. SIGNATURE OF JURY <i>John Doe</i>	
53. SIGNATURE OF JURY <i>John Doe</i>		54. SIGNATURE OF JURY <i>John Doe</i>	
55. SIGNATURE OF JURY <i>John Doe</i>		56. SIGNATURE OF JURY <i>John Doe</i>	
57. SIGNATURE OF JURY <i>John Doe</i>		58. SIGNATURE OF JURY <i>John Doe</i>	
59. SIGNATURE OF JURY <i>John Doe</i>		60. SIGNATURE OF JURY <i>John Doe</i>	
61. SIGNATURE OF JURY <i>John Doe</i>		62. SIGNATURE OF JURY <i>John Doe</i>	
63. SIGNATURE OF JURY <i>John Doe</i>		64. SIGNATURE OF JURY <i>John Doe</i>	
65. SIGNATURE OF JURY <i>John Doe</i>		66. SIGNATURE OF JURY <i>John Doe</i>	
67. SIGNATURE OF JURY <i>John Doe</i>		68. SIGNATURE OF JURY <i>John Doe</i>	
69. SIGNATURE OF JURY <i>John Doe</i>		70. SIGNATURE OF JURY <i>John Doe</i>	
71. SIGNATURE OF JURY <i>John Doe</i>		72. SIGNATURE OF JURY <i>John Doe</i>	
73. SIGNATURE OF JURY <i>John Doe</i>		74. SIGNATURE OF JURY <i>John Doe</i>	
75. SIGNATURE OF JURY <i>John Doe</i>		76. SIGNATURE OF JURY <i>John Doe</i>	
77. SIGNATURE OF JURY <i>John Doe</i>		78. SIGNATURE OF JURY <i>John Doe</i>	
79. SIGNATURE OF JURY <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>	
81. SIGNATURE OF JURY <i>John Doe</i>		82. SIGNATURE OF JURY <i>John Doe</i>	
83. SIGNATURE OF JURY <i>John Doe</i>		84. SIGNATURE OF JURY <i>John Doe</i>	
85. SIGNATURE OF JURY <i>John Doe</i>		86. SIGNATURE OF JURY <i>John Doe</i>	
87. SIGNATURE OF JURY <i>John Doe</i>		88. SIGNATURE OF JURY <i>John Doe</i>	
89. SIGNATURE OF JURY <i>John Doe</i>		90. SIGNATURE OF JURY <i>John Doe</i>	
91. SIGNATURE OF JURY <i>John Doe</i>		92. SIGNATURE OF JURY <i>John Doe</i>	
93. SIGNATURE OF JURY <i>John Doe</i>		94. SIGNATURE OF JURY <i>John Doe</i>	
95. SIGNATURE OF JURY <i>John Doe</i>		96. SIGNATURE OF JURY <i>John Doe</i>	
97. SIGNATURE OF JURY <i>John Doe</i>		98. SIGNATURE OF JURY <i>John Doe</i>	
99. SIGNATURE OF JURY <i>John Doe</i>		100. SIGNATURE OF JURY <i>John Doe</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9077

CERTIFICATE OF DEATH

Reg. Dist. No.

09046

1. PLACE OF DEATH o. COUNTY <u>Dorchester, MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN <u>1b</u> <u>From 12/12/54</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cora</u> Middle <u>Virginia</u> Last <u>Willen</u>		4. DATE OF DEATH Month <u>August</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1855</u> <u>7/4/1855</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
3. FATHER'S NAME <u>Thomas Goslin</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Harper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure.</u> 450.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis. 20 yrs.</u> DUE TO (c) <u>Gangrene of the rt. foot.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/12</u> , 19 <u>54</u> , to <u>August 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>August 22</u> , 19 <u>59</u> , and that death occurred at <u>10:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Simon Vizkatis</u>		ADDRESS (Street, city or town, state) <u>E.S.S.H. Cambridge, Md.</u> DATE SIGNED <u>8.22.59</u>	
PHYSICIAN'S NAME (Type) <u>Simon Vizkatis</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 25, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Brookview, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>		24a. REC'D BY REGISTRAR <u>AUG 26 59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur A. Rinaldi</u>	

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8-9-18

CERTIFICATE OF DEATH

0077

CHIEF OF POLICE

DEPARTMENT OF HEALTH

9062

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY DORCHESTER MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, give name and address before admission) o. STATE MARYLAND b. COUNTY DORCHESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMBRIDGE			c. LENGTH OF STAY IN 1b LIFE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 CAMBRIDGE	
d. NAME OF HOSPITAL (If not in hospital, give street address) 307 BRYN STREET				1d. STREET ADDRESS 307 BRYN STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROXIE Middle COOPER Last COOPER WILLEY				4. DATE OF DEATH Month AUGUST Day 5 Year 1959			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH oct 5, 1881		9. AGE (In years, months, and days) 77 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
3. FATHER'S NAME ALBERT COOPER				14. MOTHER'S MAIDEN NAME UNKN OWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		INFORMANT Address MRS JOHN REVELLE CAMBRIDGE MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Arteriosclerotic hypertensive cardio vascular renal disease. DUE TO (c) unknown							INTERVAL BETWEEN ONSET AND DEATH 11 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. --- 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from 1-24-57 , 19 --- , to 8-5-59 , 19 --- , that I last saw the deceased alive on 8-5-59 , 19 --- , and that death occurred at 4:45A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 15 Locust Street, Cambridge, Md. 8-6-59							
ACTUAL SIGNATURE Eldridge H. Wolff		PHYSICIAN'S NAME (Type) Eldridge H. Wolff, M.D.					
22a. BURIAL, CREMATION, OR OTHER (Specify) BURIAL		22b. DATE THEREOF AUG 7, 1959		22c. NAME OF CEMETERY OR CREMATORY DORCHESTER MEMORIAL PARK		22d. LOCATION (City, town, or county) (State) CAMBRIDGE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPT FURNAL SERVICE				ADDRESS CAMBRIDGE MARYLAND		24a. REC'D BY REGISTRAR DATE AUG 10 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

9063

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09048

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Cambridge			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 11 Cemetery Ave.				d. STREET ADDRESS 11 Cemetery Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Olin Middle Philip Last Wilson				4. DATE OF DEATH Month August Day 10 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1909		9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto Mechanic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Madison, Dor. Co.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas H. Wilson				14. MOTHER'S MAIDEN NAME Viola Travers			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-7944		17. INFORMANT Mrs. Mable H. Wilson, 11 Cemetery Ave., Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420.1 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Instant	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. John Mace Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 12, 1959		22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frederick R. Thomas</i>				24a. REC'D BY REGISTRAR DATE AUG 14 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Haines</i>	

MEDICAL CERTIFICATION

